

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/28/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 901 MACARTHUR BLVD MUNSTER, IN 46321		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 33212 Facility Number: 005106</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey 2/25-28/2014</p> <p>Date of ISDH off site review - 6/4/2014</p> <p>Reviewer/Surveyor -Nancy Otten, RN, PHNS</p> <p>Based on review of the 2/28/2014 JCAHO Accreditation Survey Report, it has been determined that Commuity Hospital of Munster meets the requirements for Hospital Licensure in Indiana for 2014.</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE